



SKULL BASE INSTITUTE

NAME: _____

Date: _____

HISTORY OF PAST ILLNESS:

Have you had

Childhood:

Measles	No	Yes	Mumps	No	Yes	Chicken Pox	No	Yes
Diabetes	No	Yes	Stroke	No	Yes	Cancer	No	Yes
Rheumatic Fever or Heart Disease.	No	Yes	Tuberculosis	No	Yes	Asthma	No	Yes
Congenital Abnormalities.	No	Yes	Seizures or Convulsions	No	Yes	Other Serious Illness	No	Yes

Adult:

Have you ever had any serious illnesses? No Yes *If yes, specify:* _____
 Have you ever been hospitalized or been under medical care for very long? No Yes
 If yes, for what reason? _____

Operations:

Have you had any surgery? No Yes
 List dates and type: _____

Injuries:

Have you ever had any accidental injuries? No Yes
 List type and dates _____

FAMILY HISTORY

Family Member	Age	If Living give Health Status	If deceased indicate cause	Age	Any blood relative ever had the following?	Yes		No		Age	Relationship to you?
						Yes	No	Yes	No		
Father					Cancer						
Mother					Tuberculosis						
Brother					Diabetes						
					Heart Disease						
Sister					High blood Pressure						
					Stroke						
Husband / Wife					Convulsions						
Son					Suicide						
					Insanity						
Daughter					Bleeding tendency						
					Arthritis						

SOCIAL HISTORY:

Circle one: Single Married Separated Divorced Widowed Are you living with your husband or wife? No Yes
 Do you consume alcoholic beverages? Never Rarely Moderately Daily No Yes
 Tobacco: Cigarettes: _____ packs a day for _____ years Cigar Never Smoked Past Smoker: _____ packs a day for _____ years
 Are you employed? Full time Part-time What is your job? _____
 Are you exposed to dusts, fumes or solvent? No Yes
 Education: Grade School _____ (years) High School _____ (years) College _____ (years) Postgraduate _____ (years)
 Have you lost time from work due to health problems? No Yes if yes, how long? _____

MEDICATIONS:

Please list the medications you are currently taking (including the dose and how often):

Do you have any medication or food allergies? No Yes
 If, yes, please list below and type of reaction

REVIEW OF SYSTEMS:

General:			Head-Eyes-Ears-Nose-Throat:		
Recent weight change?	No	Yes	Eye disease (glaucoma) or injury	No	Yes
Generally healthy most of your life?	No	Yes	Sneezing, runny nose, itchy eyes	No	Yes
Skin:			Ear disease	No	Yes
Skin Diseases	No	Yes	Dizziness or episodes of unconsciousness	No	Yes
Jaundice	No	Yes	Do you wear glasses	No	Yes
Abnormal pigmentation	No	Yes	Nosebleeds	No	Yes
Frequent skin infections or boils	No	Yes	Sinus trouble	No	Yes
Hives, eczema or rash	No	Yes	Impaired hearing	No	Yes
Neck:			Gynecological:		
Stiffness	No	Yes	Age period started : _____	How long period lasts: _____	
Neck spasm	No	Yes	Frequency: every _____ days	First day of last period: _____	
Enlarged glands	No	Yes	Any pain with your periods?.....No Yes		
Respiratory:			Number of pregnancies: _____	Number of miscarriages: _____	
URI or 'cold' now	No	Yes	Number of children: _____	Ages: _____	
Wheezing or asthma	No	Yes	Date of last pap smear: _____	Date of last Gynecologist exam: _____	
Pleurisy or pneumonia	No	Yes	Musculoskeletal:		
Spitting up blood	No	Yes	Varicose veins	No	Yes
Difficulty of breathing	No	Yes	Weakness of muscle or joints	No	Yes
Chronic or frequent cough	No	Yes	Any difficulty in walking	No	Yes
Any trouble with lungs	No	Yes	Any pain in calves or buttocks on walking relieved by rest	No	Yes
Cardiovascular:			Neuro-Psychiatric:		
Chest pain or angina	No	Yes	Convulsions	No	Yes
High blood pressure	No	Yes	Paralysis	No	Yes
Heart murmur	No	Yes	Fainting spells	No	Yes
Difficulty walking two blocks	No	Yes	Frequent falls	No	Yes
Swelling of hand, feet or ankle	No	Yes	Vertigo	No	Yes
Shortness of breath with walking	No	Yes	Frequent headaches	No	Yes
Shortness of breath while lying down	No	Yes	Migraines	No	Yes
Awakening at night smothering	No	Yes	Vision problems	No	Yes
Heart trouble or heart attack	No	Yes	Have you ever had psychiatric care?	No	Yes
Gastrointestinal:			Have you ever been advised to see a psychiatrist?	No	Yes
Hemorrhoids or piles	No	Yes	Hematologic:		
Peptic ulcer	No	Yes	Are you slow to heal after cuts?	No	Yes
Heartburn or indigestion	No	Yes	Abnormal bruising or bleeding?	No	Yes
Liver trouble	No	Yes	Excessive bleeding after procedures	No	Yes
Bleeding with bowel movements	No	Yes	Blood diseases	No	Yes
Recent change in bowel movements	No	Yes	Anemia	No	Yes
Painful bowel movements	No	Yes	Phlebitis	No	Yes
Black stools	No	Yes	Endocrine:		
Frequent diarrhea	No	Yes	Thyroid disease or nodule	No	Yes
Cramping or pain in the abdomen	No	Yes	Hormone therapy	No	Yes
Vomiting blood or food	No	Yes	Any change in hair growth	No	Yes
Difficulty swallowing	No	Yes	Any change in glove size	No	Yes
Hepatitis	No	Yes	Have you become colder than before and skin drier?	No	Yes
Gallbladder disease	No	Yes	Excessive unintentional weight gain or weight loss	No	Yes

Date of last physical examination: _____

Name of Primary Care Physician: _____

Source of Information, if other than patient: _____

Signature of Patient: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____